Testimony on Reauthorization of Indian Health Care Improvement Act
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Introduction

Good Morning, Chairman Baucus, Vice Chairman Grassley and honorable members of the Senate Finance Committee. I am Carl E. Venne, Chairman of the Crow Tribe of Indians in Montana and Chairman of the Montana –Wyoming Tribal Leaders Council and the Council of the Large Land Based Tribes. I am honored to appear before you today to present testimony on the Reauthorization of the Indian Health Care Improvement Act, certainly the most critical legislation for American Indians before this session of Congress. My presence here before you follows the efforts of other Tribal Leaders over several years who have also addressed Congress for the passage of this legislation.

The Tribes of Montana and Wyoming include the Blackfeet Nation, the Crow Tribe of Indians, the Confederated Salish and Kootenai Tribes of the Flathead Reservation, the Chippewa Cree of the Rocky Boy's Reservation, the Gros Ventre and Assiniboine Tribes of the Fort Belknap Reservation, the Assiniboine and Sioux Tribes of the Fort Peck Reservation, the Northern Cheyenne Tribe, the Eastern Shoshone and Northern Arapaho Tribes of the Wind River Reservation and the Little Shell Tribe. All Montana and Wyoming tribes are members of the Council of Large Land Based Tribes, a national tribal organization of tribes with land bases of 100,000 or more acres and with large on-Reservation populations. These large land based tribes continue to struggle with the longstanding Indian reservation issues of poverty, very high unemployment, joblessness, lack of adequate housing and the most serious issue, substandard health care.

As the debate and dialogue surrounding the reauthorization of the Indian Health Care Improvement Act continues, I would like to relate to you stories that illustrate the real-life impact of the deplorably substandard health care currently available to my people on the Crow Reservation.

Patient X is a five-year-old girl who was diagnosed with retinoblastoma, a rare form of cancer in the eye, at age five months. This condition required that her right eye be surgically removed. When she originally had the right eye removed in October of 2001, a prosthetic eye was made to fit, with the understanding that every few years, a new prosthesis would be required as she grew. At the end of last year, when it was clear that her prosthetic eye needed to be replaced, Indian Health Service Contract Health funding became an issue. Both of her parents, who recently gained employment, found themselves ineligible for Medicaid assistance and her case failed to meet medical priority criteria for Contract Health Services. Her family was left with the options of going without a new prosthesis, which could lead to a permanently disfigured face for B.Y., or seeking to raise the $3000 themselves, not an easy task for a family working hard to earn a living.

Patient Y is a 35-year-old woman who was diagnosed with an unusual heart condition that led to dramatic heart failure – for an unknown reason, her heart lost its ability to pump well, and she could hardly move without becoming dramatically short of breath. She was referred to the Mayo Clinic, where she received special cardiology care and put on the list for a heart transplant. Thanks to close monitoring, the use of many medications and a permanent pacemaker, her condition stabilized, and her ability to function improved a bit. At least she can walk a short distance now without assistance. However, due to a lack of funding, her on-going visits with the cardiologist, not to mention a heart transplant, will no longer be covered.

Many similar stories exist throughout Indian Country illustrating the shameful state of health care services for American Indian people in this most powerful and wealthiest country in the world. Statistics illustrate that Indian Health Care is at the bottom of Federal Health Expenditures with medical expenditures for federal prisoners almost double the amount allocated for American Indians. This single fact flies in the face of the mission of the Federal Government's Indian Health Service, which states:

> The mission, in partnership with American Indian and Alaska native people, is to raise their physical, mental, social and spiritual health to the highest level. The Goal is to ensure that comprehensive, culturally acceptable personal and public heath services are available and accessible to all American Indian and Alaska Native people. The Foundation is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities and culture, and to honor and protect the inherent sovereign rights of Tribes.

Without adequate funding, the mission statement of the Indian Health Service, while ambitious and noble, is meaningless. Why has providing adequate health care to America's first people become such a low priority in the development of the federal budget over the last decades? Lawmakers need to revisit the sacrifices of aboriginal lands by Indians in exchange for the federal government's commitment to provide health care. The federal government's trust responsibility has been established over and over in treaties with Tribes and Executive Orders. These treaties were entered into between two sovereign entities; thus, the federal government's obligation to provide health care is a legal commitment to another political entity, America's Indian Nations. Health care for American Indians is not a race-based privilege but a legal obligation to a political group; an obligation the United States must uphold. One should contrast the United States deplorable demonstration of trust responsibility with the Tribes' commitment to the treaties as clearly demonstrated by the record number of American Indians serving in the Afghanistan and Iran conflicts.

While the United States has been faced with the devastation of natural disaster and the ever-increasing challenges of financing oversees military operations, it cannot forget its legal obligations to the first Americans. The United States commits billions of dollars to foreign aid including aid to third world countries for health care in furtherance of humanitarian efforts. However, the United States has ignored its legal obligation to American Indians here within the borders of the United States. The time is now for Congress to recommit to its trust responsibility for health care for American Indians. The

Montana – Wyoming Tribal Leaders and the Council of the Large Land Based Tribes have expressed concerns in the following areas.

Health Disparities

No other segment of the United States population is more negatively impacted by health disparities than American Indians. Our Tribal members suffer from disproportionately higher rates of chronic disease and other illnesses. Native Americans have the highest rates of diabetes, heart disease, suicide, and several types of cancer of all other groups in the United States.[1] In the Great Plains Region, we suffer from one of the highest infant mortality rate in the nation.[2]

While the federal government's mission statement for American Indian health care has lofty objectives, in reality the Indian Health Services is unable to deliver health care that is even remotely comparable to the health care available to other Americans. Presently the Indian Health Service hospitals and clinics have an average age of 33 years compared to 9 years for average U.S. hospitals and clinics. The Indian Health Service is only able to provide 73.9 medical doctors per 100,000 Tribal members as compared to 220.6 MDs available to the non-Native U.S. population, constituting a 66% gap in physician availability between Natives and non-Natives. Furthermore, 229 nurses are available per 100,000 Tribal members compared to 849 nurses available for every 100,000 people in the United States, constituting a 73% gap in nurse availability between Natives and non-Natives.

Budget

While the President's budget recommended an increase in nearly every line item in the Indian Health Service's budget, this increase is not sufficient to maintain even the status quo of poor health care for American Indians. While we greatly appreciate the increases in funding over the last several years, the 7% funding increase cannot begin to provide adequate health care with the rising costs of health care and the population increases of American Indians. Between 1995 and 2005, IHS revenues grew by 75%,

[1] *See, e.g.*, U.S. Dept. of Health and Human Services, Indian Health Service, "Trends in Indian Health 2000-2001". [http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/files/Trends00-01_Front.pdf]
[2] *Ibid.*

while inflation grew by 56% and number of users grew by 14%, resulting in flat buying power per individual patient.

The present $4.1 billion budget request amount is seriously below the Indian Health Service FY06 "Needs Based Budget" indicating at least $19.7 billion was necessary for adequate health care. The present budget request would allow the Indian Health Service to meet only 60% of established needs, falling far short of even maintaining the appalling conditions of status quo health care. The Indian Health Services has historically used the "Rules Based Budgeting" process that has not kept pace with actual cost and inflationary rates since 1954.

For example, the Indian Health Service budget in 2003 allowed for approximately $2130.00 per individual[3] as opposed to general health expenditures for the United States population of $5065.00.[4] Additionally, it is useful to compare 2003 IHS expenditures at $2130.00 per capita and actually $1688.00 per capita in the Billings Area and 2003 Veterans Administration expenditures at $5214.00 per capita[5] – VA expenditures per capita are more than double the IHS per capita expenditure. Recent revelations about the intolerable state of the Veterans Administration services and facilities make this discrepancy even more disgraceful.

Contract Health

All Tribes have expressed a serious concern for the shortfall in Contract Health Care, health care that is unavailable within the Indian Health Service that must be purchased via contract in the private and public health services sector. During recent Indian Health Service Budget Formulation meetings, Tribal Leaders and Billings Area IHS staff determined that augmenting the Contract Health Services was the number one priority. Presently $30 million dollars is available for the Montana – Wyoming Tribes. No tribe has over $5 million to access surgeries and specialized health care not available within the Indian Health Service. With the costs of surgeries and specialized treatments,

[3] Source: Indian Health Service budget and appropriations tables for 2005. Expenditures from appropriations plus collections are divided by the 2005 HIS user population to compute actual expenditures per user.
[4] Centers for Medicare and Medicaid Services website, 2/6/2006. [http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nheprojections2004-2014.pdf]
[5] Veterans' Administration website, 2/6/2006. [http://www.va.gov/vetdata/ProgramStatics/stat_apps02/Table%2011%20(02).xls]

these dollars cover only a portion of the need. Thus, many of our Tribal members go without treatment that is accessible to the average American. Many medical procedures are "deferred" to later dates when the procedures usually are more expensive and the patient's condition has worsened. At present, contract health is so seriously limited that a person must be at risk of losing life or limb before qualifying for contract health care dollars. While an increase in the Contract Health Service line item has been proposed, the increase is far from sufficient to meet current needs and allow coverage for medically necessary services that do not reach the current life or limb standard.

For example, in one service unit, an adolescent was in need of a heart transplant. The procedure had to be covered by contract health funds. This procedure was medically necessary to save the life of a young person. The procedure cost over $1 million, or approximately half of the contract health budget for that service unit, which is $2.5 million. Half of the contract health budget for this service unit, which serves over 6000 people, was used for one person. The current budgeting process does not allow for adjustments to adequately address such situations.

Additionally, Native Americans between the ages of 25-44 are 3.7 times more likely to die from accidental or unintentional injury than the general population. One recent head injury in our service unit cost $177,000 in contract health dollars. This is an example of the cost of a traumatic injury to one single individual. The impact of this type of occurrence, which is statistically more likely to occur within our populations, on the contract health services budget cannot be overemphasized.

Over the past year, three permanent staff physicians have resigned from our hospital at Crow Agency, including one physician who had been a part of IHS for over 15 years. While each of these physicians had additional personal concerns that factored into their choice to leave the IHS, a common motivator for all three was frustration over how underfunding was steadily deteriorating the quality of care they were able to provide to their patients. Specifically, each noted that the lack of contract health service funding compromised the quality of care they were able to provide and undermined their relationships with patients. Three additional physicians who are considering an imminent departure from the hospital cited these same concerns.

Medicare Modernization Act

Section 506 of the Medicare Modernization Act requires the Secretary of HHS to develop regulations that that will require Medicare participating hospitals to accept the Medicare rate as payment in full for services provided to American Indians referred under the Contract Health Service program. Currently, in some areas, the Indian Health Service must pay full-billed charges to private and public sector hospitals for services provided to American Indians. Publishing these mandated regulations that were required by Section 506 for publication in December 2004 will ensure that the Indian Health Service pays rates similar to Medicare rates paid to Medicaid participating hospitals.

Preventative Health Care

While cancer rates in the general population have declined due to an increase in preventative services, a lack of funding has prevented the provision of cancer education and screening for early detection of cancer in Indian Country. Thus, cancer among American Indians has not declined and is the third leading cause of death for all American Indians. Further, American Indians have the poorest cancer survival rate in comparison to other racial and ethnic groups in the United States. While the President's budget includes funding for effective disease prevention, the amount is not sufficient. We need sufficient funding for cancer screenings to allow treatment before the end stages of cancer that is presently the starting point for intervention and treatment.

Traditional Health Care Models

Tribes have compacted and contracted health care services under the Indian Self-Determination and Education Assistance Act in an effort to provide culturally relevant treatment methods. On the Crow Reservation, we have contracted with the Indian Health Service to provide a culturally relevant substance abuse treatment program. Our facility, known as the Seven Hills, has been more successful for Crow people battling substance abuse than standard treatment methods. We have incorporated the sweat lodge ceremony, elder counseling and other cultural aspects into an effective treatment process with success rates far exceeding standard success rates. However, we read the Department of Justice's "white paper" regarding its concerns about traditional treatment

alternatives that tribes may provide through contracting or compacting with the Indian Health Service. Specifically, the concern was that Federal Torts Claims coverage may not apply and therefore, such alternative treatment methods should not be allowed via contract or compact. However, at Crow, we have never had anyone submit a claim or complaint against Seven Hills during its three-year existence to date. Further, we have been unable to verify that even a single tort claim has been attempted for any traditional treatment service provided by contract or compact by a tribe in the Billings IHS Area. Thus, the concern expressed by the Department of Justice is without basis and should not bar treatment alternatives that have proven success rates.

IHS Must be a Primary Provider Rather than a Payor of Last Resort

Prior to the Indian Health Care Improvement Act, health care for American Indians was paid entirely by the Indian Health Service. In the mid-1970's, the IHS was designated as the Payor of Last Resort and American Indians were required to seek other sources for payment of health services that the IHS could not provide in IHS hospitals and clinics. Thus, when a Tribal person has a catastrophic illness, he or she often must seek payment through Medicaid or Medicare prior to IHS funding. The time delay involved in seeking alternate forms of payment can exacerbate a life-threatening condition, and can, in some instances, impact a patient's ability to be treated. When a Tribal member suffers from an acute illness, the time involved to seek alternative funding (often with at least a 30 to 60 day turnaround time) will interfere with timely, effective treatment. Requiring American Indians to endure the stress and hardship of seeking alternative payment sources is contradictory to the IHS trust responsibility to provide health care to all American Indians.

Funding for Behavioral Health Services

Presently, the Indian Health Service has extremely limited funding to provide psychiatric, psychological and behavioral health services for adults and most significantly, for adolescents. Little to no funding is available for residential treatment services for adolescents in desperate need of behavioral intervention. Additional services to address behavioral health are critical.

For many Native American communities, there is a lack of understanding of the role of behavioral health in health promotion and disease prevention. Many chronic health conditions are linked to life-long behavior patterns, and therefore can be prevented by a change in lifestyle. Native Americans are at a higher risk for mental health disorders than other racial and ethnic groups in the United States, and are consistently overrepresented among high-need populations for mental health services, correlated to high rates of homelessness, incarceration, alcohol and drug abuse, and stress and trauma in Native American populations. Substance abuse and depression are epidemic among the Native American community, and are commonly attributed to isolation on distant reservations, pervasive poverty, hopelessness, and intergenerational trauma, including the historic attempts by the federal government to forcibly assimilate tribes. Additionally, Wyoming has been ranked number one nationwide and Montana number two, both within the Billings HIS Area, for methamphetamine abuse. However, unfortunately, due to inadequate funding, the IHS does not provide ongoing preventative psychiatric care, and has instead adopted an approach of crisis stabilization—responding to immediate mental health crises and stabilizing patients until their next episode.

We are all painfully aware of the high suicide rate among American Indians and especially in American Indian adolescents. For example, a 2003 report by the Centers for Disease Control states that Native Americans are nearly three times more likely to commit suicide than the general United States population. An additional CDC report compiling information from 1979 through 1992 shows Native Americans suffering from a 150% higher suicide rate compared with that of the general United States population. In the Billings service area, the death rate from suicide is 8.6 per 100,000, as compared with 3.0 per 100,000 for the general population. Other IHS areas serving large land based tribes have even more abysmal rates – the Aberdeen area has a rate of 19.6 per 100,000; Bemidji has a rate of 10.7 per 100,000; Tucson has a rate of 18.8 per 100,000.

The inability to treat individuals in need of behavioral health services is beyond frustrating to our local practitioners. One behavioral health practitioner recently decried the state of behavioral health services at a Montana IHS hospital: "Our service unit has no access to a child psychiatrist and no contract care funding for any individual psychiatric consults for any of our children. We currently have [an adolescent] with a long history of

severe mental illness and violence who has run out of insurance coverage for payment of [the patient's] residential mental health placement. [The patient] will shortly be released to return to the community because there is no contract care funding to support [the patient's] continued care. [The patient] will have to be charged with a serious crime in order to receive any secure placement or residential treatment. Native Americans have the highest suicide rate of any ethnic group and we have no funds to provide for any extended inpatient treatment for either adults or children."

Title VII of the Indian Health Care Improvement Act expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. However, the expansion of behavioral services should occur in a manner that allows programs to be tailored to Tribal priorities.

Health Care for Native American Veterans

Finally, I would like to address a concern near to my heart as an American Indian Veteran. American Indians have enlisted and historically served in the armed forces to defend this country in numbers that far exceed any other segment of the United States population. Presently, I have been provided figures that indicate approximately 17% of the armed services, including all branches, are American Indians while we comprise less than 2% of the overall population. Our commitment to defend this soil, standing side by side with our American brothers and sisters, has been unwavering since World War One. And as other Veterans, our American Indian Veterans suffer from limited health care services. I request that Congress recognize the service of our Tribal Veterans and facilitate access to health care services within the local Indian Health Service facilities. The Indian Health Service should be able to provide all required medical services including mental health counseling for Post Traumatic Stress Syndrome to Native American Veterans and receive reimbursement from the Veterans Administration. Presently, our Native American Veterans are required to travel to Veteran's hospitals that are generally long distances from the Reservations resulting in a hardship that prevents access to paid health services.

Conclusion

I urge Congress to reauthorize the Indian Health Care Improvement Act as a starting point to begin realistically fulfilling its trust responsibility to American Indian and Alaska Natives in these United States. In 2004, IHS was funded at 56.8% of the level of need, with a deficiency of approximately $1.7 billion. Compare this to the estimated monthly cost of the war in Iraq of $4.5 billion. This great nation is capable of doing better by Native Americans. When those Native American men and women fighting the war in Iraq come home, they deserve to have access to the same level of health care that all Americans have come to expect. This is why we send our sons and daughters to fight for this Nation – the promise of a share in the American dream and American quality of life.

The Indian Health Care Improvement Act will bring up to date Indian Health Service facilities and services. It will allow for programs to address behavioral and mental health issues that have been severely neglected under the current system. It will begin to address the horrifying and inexcusable disparities between the health levels of Native Americans and the general United States population.

While the most critical need to remedy the deplorable level of health care for Native Americans is a realistic financial commitment, the Indian Health Care Improvement Act is legislation that is necessary to increase the availability of health care, develop new approaches to health care delivery, increase the flexibility of the Indian Health Service and promote the sovereignty of American Indian Tribes.

I thank you again for the opportunity to present this testimony and look forward to a positive working relationship between Tribal Governments and Congress to address the health of American Indians.